Private thoughts of public representatives: Assisted death, voluntary euthanasia and politicians

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Assisted death and voluntary euthanasia have received significant and sustained media attention in recent years. High-profile cases of people seeking assistance to end their lives have raised, at least in the popular press, debate about whether individuals should be able to seek such assistance at a time when they consider their suffering to be unbearable or their quality of life unsatisfactory. Other recent developments include a number of attempts to legislate on the issue by the minor parties in Australia and the successful enactment of legislation in a few overseas jurisdictions. However, despite all of the recent attention that has focused on assisted death and voluntary euthanasia, a discussion of the adequacy of existing laws has not made it onto the political agenda of any of the Australian State or Territory governments. This is in spite of the fact that the private views of the majority of our elected Members of Parliament may be supportive of reform. This article explores the role of politicians' views and, as a case study, considers the opinions expressed by a number of Queensland Members of Parliament. In light of the views of these politicians and those of members of the public, as well as considerations arising from current medical practice, the article argues that there is a need for open political debate on assisted death and voluntary euthanasia. The article also suggests ways that such a debate may be achieved while minimising any political impact on governments that are prepared at least to consider this issue.

INTRODUCTION

There have always been many voices in the euthanasia debate. Voluntary organisations such as Right to Life Associations and Voluntary Euthanasia Societies are vocal when the topic arises in the media. Churches, the peak medical body – the Australian Medical Association – and the media itself are powerful and influential players. The public, too, seeks to be heard on the topic and many surveys[1] have been carried out to assess the community stance on physician-assisted death and euthanasia.[2]

What is of more recent interest, however, is that these voices are starting to speak more loudly and, in some cases, they are being heard. There have been two main forums for these voices. The first is the media. Coverage in the press about euthanasia and assisted death has been more prominent in recent history with the stories of people such as Mrs Nancy Crick and Ms Sandy Williamson in Australia and Mrs Diane Pretty in the United Kingdom attracting a lot of media interest.

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[1] See below n 33.
[2] Physician-assisted death occurs where a physician takes certain action, eg, prescribing sufficient doses of medication, to enable the patient to bring about her or his own death. Voluntary euthanasia, on the other hand, occurs where, at the patient's request, the physician herself or himself does the act, such as administering the lethal dose, which brings about the patient's death.

The second forum where euthanasia and assisted death have been receiving more attention, albeit unsuccessful attention, is in various Australian State Parliaments. Three State Parliaments are currently considering voluntary euthanasia Bills. The South Australian House of Assembly is considering its *Dignity in Dying Bill 2003* (SA) while the Legislative Council also has before it an identical Bill introduced the year before. New South Wales has its *Rights of the Terminally Ill Bill 2003* (NSW) which is the third Bill on the topic in recent times following the *Voluntary Euthanasia Trial (Referendum) Bill 2002* (NSW) and the *Rights of the Terminally Ill Bill 2001* (NSW). Finally, the *Voluntary Euthanasia Bill 2002* (WA) is currently before the Western Australian Parliament. Although the topic of euthanasia and assisted death has always been simmering beneath the surface, the last 18 months have seen the issue become more prominent in both the public and political spheres. As mentioned, the voices in this debate are speaking more loudly and are starting to be heard.

One of the voices that is frequently missing from the debate, however, is the personal views of our elected politicians, and particularly those from the major parties. While it is commendable that a number of State Parliaments are at least thinking about these issues, it is disappointing that the discussion has been driven by the minor parties.[3] The majority of mainstream politicians has tended to avoid disclosing their personal views on the issue of euthanasia and assisted death. The irony of this situation is obvious. Should legislative change be mooted, politicians are likely to be permitted to vote according to their conscience rather than along party lines. The personal views of politicians may therefore be crucial in the euthanasia debate, and in assessing the likelihood of legislative reform.

It was for these reasons that in May 2002 the authors sought to conduct a case study based on surveying the personal views of the Members of State Parliament in Queensland. The choice of Queensland State politicians as the subject for the case study was made for a number of reasons. The first is the obvious convenience of location. The authors are based in Brisbane so accessing Queensland politicians was going to be easier than those from other States or Territories. The second reason is that Queensland is one of the States where this issue has been subjected to intense media scrutiny. The life and death of Mrs Nancy Crick, who lived in Queensland, was at the centre of this debate for a number of months.

The third reason is that the approach to this issue by politicians in Queensland is a good example of how theirs has been one of the key voices missing from this debate. It has been very difficult to find records or comments where Queensland politicians have committed themselves publicly to a personal view. In fact, the tendency has been quite the opposite, with techniques of avoidance or distraction being employed. The authors' goal in surveying Queensland politicians was to try and get past the "smoke and mirrors" to see what the politicians actually thought.

A final issue was the exclusion from the case study of Commonwealth politicians, even if based in Queensland. They were excluded because, apart from their involvement in overturning the Northern Territory's legislation in 1997, the momentum on this issue seems to be located at State level.[4]

The purpose of this article is threefold. First, it describes the current status of the euthanasia debate in Australia. It starts with the existing and proposed legislation in different States before turning to the results of the survey. The importance of what our politicians actually think has already been noted so this survey sought to draw out the personal views of Queensland Members of Parliament. Although there are undoubtedly some local factors that may influence politicians' opinions, this issue is one of national significance. It is unlikely that there would be much variation in the personal views of politicians from State to State. The hope is that this case study will provide an insight into how politicians in other States might deal with this controversial issue.

Second, the article argues that, in light of community views and current medical practice, the euthanasia debate is one that must occur, and that this issue should be discussed openly in the political arena. Euthanasia and assisted death have been avoided by mainstream politics for too long.

Third, the article identifies some key features and obstacles that seem to have hindered this open political discussion to date. The authors conclude by making suggestions as to how this debate could

[3] The Bills mentioned above were introduced by the Greens in New South Wales and Western Australia, and by the Democrats in South Australia.

[4] No doubt this is largely due to constitutional constraints. It is likely that regulation of euthanasia and associated issues falls within the constitutional domain of the States rather than the Commonwealth.

be advanced and, in particular, how governments could safely place the issues of euthanasia and assisted death on their political agenda.

A final point that should be made is about terminology. The euthanasia debate is one that can be confused by terminology, so at the outset, it is important to be clear about how the term will be used. "Euthanasia" is defined in the *Concise Oxford Dictionary* as "gentle and easy death; bringing about of this, esp in case of incurable and painful disease". This definition is broad enough to encompass the bringing about of a patient's death *with or without* that patient's consent. The goal of this survey was more narrow, however, as the views of Queensland Members of Parliament were sought only in relation to a patient seeking to end her or his own life – that is, actions taken only with the consent of the patient. This is commonly referred to as voluntary euthanasia. Involuntary euthanasia (causing death without the patient's consent) raises different issues, which were neither canvassed in the surveys of Members of Parliament nor discussed in this article. When the term "euthanasia" is used, unless the contrary is indicated, it is a reference to voluntary euthanasia.

LEGAL DEVELOPMENTS IN AUSTRALIA

Existing legislation

Since the repeal of the Northern Territory legislation in 1997,[5] there is no law in Australia that allows a physician to assist a person to die. Voluntary euthanasia has never been lawful in Australia. The only legislation relevant to this debate is the *Consent to Medical Treatment and Palliative Care Act 1995* (SA), which statutorily enshrines the "doctrine of double effect". The basic principle of the doctrine is that it protects from liability a health care professional who gives increasing doses of a drug to relieve a patient's pain and suffering even though these drugs are also likely to shorten that patient's life. This doctrine is examined further in the context of the survey of Queensland politicians.

The protection provided by the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) is subject to a number of conditions. The intention of a doctor must be to relieve the patient's pain and suffering, consent must be obtained from the patient (or representative), and the treatment must be carried out in good faith and without negligence.[6]

Proposed legislation

Although the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) is the only law to have been enacted, there has been considerable agitation for reform in a number of Australian jurisdictions in recent years. A number of voluntary euthanasia Bills have been introduced into various State Houses of Parliament.

South Australia

In May 2002, Ms Sandra Kanck of the Australian Democrats introduced her *Dignity in Dying Bill 2002* (SA) in the South Australian Legislative Council, while in March 2003, Independent Dr Bob Such introduced an identical Bill in the House of Assembly.[7] These Bills are in the same form as the unsuccessful Bills that Kanck and Such simultaneously introduced in the two houses of the South Australian Parliament in March 2001.[8] The *Dignity in Dying Bills* allow a person who is "hopelessly ill" to request voluntary euthanasia. They also allow this request to be made in advance of the person becoming hopelessly ill, the request taking effect when the person reaches this state. Both Bills are currently before their respective houses.

New South Wales

In November 2001, Mr Ian Cohen from the Greens Party introduced the *Rights of the Terminally Ill Bill 2001* (NSW) in the New South Wales upper house, the Legislative Council. Clause 4 of the Bill permitted a patient with a terminal illness and "experiencing pain, suffering or distress to an extent

[5] *Rights of the Terminally Ill Act 1995* (NT) repealed by *Euthanasia Laws Act 1997* (Cth).
[6] *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s 17. The section also provides protection where life-sustaining measures are not applied or are discontinued.
[7] *Dignity in Dying Bill 2003* (SA)
[8] These Bills did not become law. The one in the House was discharged while the Council Bill lapsed due to prorogation.

unacceptable to the patient" to ask her or his doctor to help the patient end her or his life. The Bill lapsed in February 2002 and, although restored shortly after, was finally defeated in March 2003.

The Greens subsequently drafted a further Bill proposing a referendum on whether an 18-month legally and medically supervised trial of voluntary euthanasia should take place. Notice was given in April 2002 of an intention to introduce the *Voluntary Euthanasia Trial (Referendum) Bill 2002* (NSW) in the Legislative Council but this lapsed with the March 2003 elections. After his re-election, Cohen gave notice in April 2003 that he will introduce the *Rights of the Terminally Ill Bill 2003* (NSW) in the Legislative Council.

Western Australia

There have been a number of unsuccessful attempts to enact euthanasia laws in Western Australia. Voluntary euthanasia Bills were introduced into the State's upper house, the Legislative Council, by Democrat Mr Norm Kelly in 1997, 1998 and twice in 2000. The then Coalition Government opposed the Bills so they lapsed without parliamentary debate.[9]

A member of the Greens Party, Mr Robin Chapple, introduced the *Voluntary Euthanasia Bill 2002* (WA) into the Western Australian Parliament in September 2002. The Bill builds on Kelly's previous attempts and permits a doctor to bring about the death of a person who has both an illness that will "most likely cause the death of that person" and a desire to die because of the associated pain and suffering or debilitation. The Western Australian Premier, Dr Geoff Gallop, has indicated that Labor Members of Parliament will be entitled to a conscience vote on this Bill.[10]

Queensland[11]

One Queensland politician, in response to the survey forwarded to him, advised of his intention to introduce a Private Member's Bill into Parliament. Mr Peter Wellington, the Independent Member for Nicklin, introduced into Parliament in June 2002 the *Care of Terminally-Ill Patients Bill 2002* (Qld). In the words of Mr Wellington, the Bill "will give doctors the confidence to prescribe enough medication to relieve pain and suffering in the terminally ill without fear of prosecution",[12] even if the measures taken incidentally shorten life. The Bill is designed to statutorily enshrine the common law protection embodied in the doctrine of double effect, and to remove any doubt concerning the possible criminal and civil consequences of such action.[13] Pursuant to the Bill, a medical practitioner is not regarded as hastening the death of a person if pain relief is administered in accordance with the following conditions:

- the patient is in the terminal phase of a terminal illness and is in such severe pain that adequate relief from the pain can only be obtained by the administration of pain-relieving drugs in doses that may shorten the patient's life;
- the patient has consented to administration of the drugs (and if the patient has impaired capacity, consent is obtained under the relevant provisions of the *Guardianship and Administration Act 2000*); and
- the treatment must be administered with the sole intention of relieving pain or distress –
  (a) in good faith and without negligence; and
  (b) in accordance with proper professional standards of palliative care.

In February 2003, Mr Wellington withdrew this Bill and introduced in its place the *Criminal Code (Palliative Care) Amendment Bill 2003* (Qld). He cited as his reason for this action concerns that the Queensland Government had about the drafting of the first Bill.[14] The later Bill achieves largely the same effect as the earlier one but does so through an amendment to the *Criminal Code* (Qld). The Bill inserts s 282A Palliative Care into Ch 26 of the Code: "Assaults and Violence to the Person Generally

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[9] Western Australian Legislative Council, *Hansard*, 19 October 2002, p 2390. See also ABC Report, Transcript, 1 Dec 2002.
[10] "Death Bill a Possibility", *The West Australian*, 4 March 2003.
[11] For legal developments since this article was submitted for publication, see Postscript at the end of this article.
[12] Queensland Parliament, *Hansard*, 19 June 2002.
[13] This would provide protection similar to the South Australian legislation, *Consent to Medical Treatment and Palliative Care Act 1995* (SA), discussed above.
[14] Queensland Parliament, *Hansard*, 12 March 2003.

– Justification and Excuse". Although the Bills are similar in most respects, an important difference is that the later Bill does not require the consent of the patient (or representative). The Bill was passed by the Queensland Parliament in April 2003 and, at the time of writing, is awaiting Royal Assent.

THE SURVEY

The survey sought to elicit the personal views of Queensland politicians on a limited number of very specific issues. To maximise the response rate, the survey was conducted on an anonymous basis and respondents were not asked to provide any personal information about themselves or their political alliances. The survey was only two pages in length and contained six questions, one of which consisted of a number of parts. Politicians were asked whether it was their personal view that:

- in some circumstances, a doctor should be permitted by law to assist a mentally competent patient, with that person's consent, to bring about her or his death (Question 1);[15]
- a doctor should be able to give increasing doses of a drug to relieve the pain and suffering of a patient, when the doctor knows that such doses are likely to ultimately hasten the patient's death (Question 3); and
- a mentally competent adult patient should be able to refuse medical treatment, including life-saving treatment (Question 4).

Respondents who answered "yes" to Question 1 were asked to answer Question 2. Question 2 explored the circumstances in which the respondent considered it appropriate for a doctor to provide such assistance. These circumstances included the existence of a terminal illness or when a patient is in severe pain or distress.

The survey also provided an opportunity for Members of Parliament to make any other comments on the issues raised in the survey (Question 5). A final question invited respondents to comment upon whether it would be desirable for the Commonwealth to be involved in facilitating uniform legislation, or whether it was something best left to the States.[16]

The survey was mailed to the electoral office of all 89 serving Members of Parliament and they were asked to respond within approximately three weeks. A total of 33 parliamentarians responded, representing a 37% response rate. That a third responded to the survey was encouraging, given the competing demands of their parliamentary position. Assisted death is also an emotionally charged and politically contentious issue and, as observed by academic writers, there is very little political mileage in engaging in this debate. This is particularly so for politicians supporting legislative reform. It has been suggested that a politician who is not in favour of reform in this area is unlikely to lose the support of constituents who do favour such reform. On the other hand, a politician who favours reform to make assisted death and euthanasia lawful may well be in danger of losing constituents who oppose change.[17] With this in mind and given the controversies surrounding the death of Nancy Crick in Queensland in 2002, the response rate indicates that many Queensland politicians feel strongly about this issue.

Although it was encouraging that a third of Queensland politicians were prepared to respond to this survey, some care is needed in analysing their replies. It is likely that those who have strong views on the issue – either in support of or opposed to legislative change – are more likely to respond. However, while some caution is warranted, this does not mean that these opinions can be disregarded. Indeed, as part of this article argues, it is these uniquely personal views of politicians that will have a significant impact on the future of this debate in Queensland.

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[15] This question was worded generally around the issue of a patient's *consent* and did not seek specifically to distinguish between physician-assisted death and voluntary euthanasia (as defined above, n 2).

[16] Whether the Commonwealth or States are the appropriate bodies to have the carriage of these issues is outside the focus of this article. The responses to this question, therefore, will not be pursued any further in this article. Of the 23 respondents who answered this question, 8 (35%) thought it should be regulated by the States, 14 (61%) thought that the Commonwealth should be responsible and 1 (4%) suggested the Commonwealth, but in the absence of such legislation, the States.

[17] Skene L, *Law and Medical Practice: Rights, Duties, Claims and Defences* (Butterworths, 1998) p 241, quoting comments of Dr Roger Magnusson, Senior Lecturer in Law, University of Sydney and researcher in euthanasia.

ANALYSIS OF RESPONSES

The responses to the surveys provide interesting insights into the views of some of our politicians. The first question was critical as it explored the respondent's personal view on whether there are any circumstances in which a doctor should be permitted to assist a mentally competent patient to bring about their death, should the patient wish to do so. As the law currently stands throughout Australia, a health care professional who acts in this way is exposed to the risk of criminal prosecution. If he or she assists a patient to die, for example by prescribing sufficient quantities of medication which, if taken, would cause death, that person may have committed the criminal offence of assisting a suicide.[18] If the health care professional goes further and is actively involved in the death, for example by administering the lethal dose, he or she may have committed murder,[19] and may be charged accordingly.[20] Consent of the patient does not relieve the person involved from criminal liability.[21]

Politicians who answered "yes" to this question therefore support a change to existing Queensland laws on assisted death and euthanasia. Of the 33 respondents to the survey, 31 (94% of respondents) answered this question. Of those who responded, 17 (55%) agreed that a doctor should be permitted to assist a patient to die in some circumstances.

Such support is consistent with community views in Australia. A poll conducted in 1996 indicated 75% of the Australian community supported legalised euthanasia.[22] Community support for euthanasia is also reflected in surveys conducted in Queensland. A survey completed by 486 Queenslanders who were randomly selected from the electoral roll inquired about views on physician-assisted suicide and euthanasia. A total of 60% supported a doctor being allowed to assist a terminally ill person to die in certain circumstances; 65% of the same group considered that the law should be changed to allow active voluntary euthanasia in certain circumstances.[23]

Surveys of the Australian medical profession also indicate majority support for euthanasia, although not to the same extent as the general community. A 1994 survey of 1,268 doctors in New South Wales and the Australian Capital Territory indicated that 59% supported active euthanasia in certain circumstances.[24] A survey of Queensland health care professionals carried out around the same time indicated a lower degree of support for assisted suicide and voluntary euthanasia. In the Queensland survey, 43% of health professionals supported assisted suicide in certain cases, and the same percentage thought the law should be changed to allow euthanasia in some circumstances.[25] The Australian Medical Association has taken a relatively conservative view and remains opposed to amending laws to make voluntary euthanasia or assisting a patient's death lawful. This position was confirmed following a vigorous debate of the issue at its 2002 national conference.

Although there are difficulties inherent in comparing different surveys, it appears, then, that the views of the politicians who responded are generally consistent with the trends across Australia (or Queensland). The percentage who support a change in the law (55%) is greater than that which exists in the health care profession in Queensland, although it is less than that which exists in the profession in New South Wales and the Australian Capital Territory. The percentage of politicians in support of

[18] *Criminal* Code (Qld), s 311. Equivalent provisions exist in all other Australian jurisdictions.
[19] *Criminal* Code (Qld), s 302. Equivalent provisions exist in all other Australian jurisdictions.
[20] See, eg, the English case of *R v Cox* (unreported, Winchester CC, 18 Sept 1992). Dr Cox was charged with and convicted of attempted murder after injecting his patient with potassium chloride. His patient was 70 years old, close to death and suffering agonising pain from her rheumatoid arthritis. The patient had bedsores through to the bone, was blind, doubly incontinent and, according to nursing staff, suffered unbearable pain when she was touched. She had begged Dr Cox to end her suffering by administering a lethal dose of medication. (The charge was attempted murder rather than murder because the prosecution was unable to prove that it was the injection rather than the condition which caused her death.)
[21] *Criminal* Code (Qld), s 284.
[22] Newspoll 1996, the results of which were reported in *The Australian*, 9 July 1996.
[23] Steinberg MA, Cartwright CM, Najman J, MacDonald SM and Williams G, in "Healthy Ageing, Healthy Dying: Community and Health Professional Perspectives on End of Life Decision Making" (Feb 1996), p xii. This survey distinguished between active voluntary euthanasia, where medical intervention takes place to end a patient's life, and voluntary passive euthanasia, where a patient's life is ended by withdrawing or withholding treatment. This is not a distinction that this article pursues.
[24] Baume P and O'Malley E, "Euthanasia: Attitudes and Practices of Medical Practitioners" (1994). This survey also distinguished between active and passive euthanasia.
[25] Steinberg et al, n 23, p xiv.

changing the law is also less than that which exists in the broader Australian (or Queensland) community.

Question 3 explores whether a doctor should be able to give increasing doses of a drug to relieve the pain and suffering of a patient, even though the doctor knows that such doses are likely to hasten a patient's death. The existing law in Australia appears to provide protection to health care professionals acting in this manner, provided the primary intention of the doctor is to relieve the person's pain.[26] The fact that a secondary consequence of the action is to bring about the patient's death will not expose the practitioner to criminal liability. This is the doctrine of double effect that was discussed above in the context of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) and Queensland's recent *Criminal Code (Palliative Care) Amendment Act 2003* (Qld).

Of the 33 respondents to the survey, 27 (82%) answered this question. Of these, 20 (74%) believed that doctors should be able to act in this way. An additional five (18%) responded that such action was acceptable provided the prior consent of the patient was obtained. This added requirement suggested by five politicians is interesting given that the law, at the time of the survey, appeared to provide protection for doctors acting in this way even where express consent is not obtained from the patient. The remaining two politicians were of the view that a doctor should not be permitted to take such action.

It is interesting to compare responses to Questions 1 and 3. A total of 55% of respondents approved of a doctor assisting a patient in bringing about her or his own death (Question 1 responses), while 74% thought it appropriate for a doctor to bring about the death of a patient by the use of increasing doses of medicine (Question 3 responses). Yet, in both cases death resulted, either directly or indirectly, from the actions of the doctor. Moreover, in the scenario described in Question 1, the acts were done with the patient's consent, while in Question 3 the consent of the patient was not obtained.

The law as it applies to these scenarios is clear. A doctor will be acting illegally in the first case, but will be protected in the second. Yet perhaps the moral and ethical distinctions between the two cases are difficult to draw. In both scenarios, although the doctor is acting in the patient's best interests, it is that conduct which causes the patient's death. Further, a health care professional may be exposed to criminal liability in the first case even though the patient has consented to the treatment, yet not in the second case where such consent may not have been given.

In trying to justify the different legal consequences, it is interesting to observe that the conceptual basis of the doctrine of double effect (the legal ground for protecting the health care professional in the second case) has been criticised.[27] It has been suggested that the doctrine provides protection because the professional's action is not "primarily" intended to cause death, but instead to provide pain relief. While the intention of the doctor in administering the medication is undoubtedly to relieve pain, if a doctor knows that administering such a dose will result in death, on a strict legal analysis it is difficult to suggest that the doctor did not intend death to result from such action. The second possible basis of the doctrine is that it is the underlying condition that caused the death rather than the administration of the medication. However, this, too, represents something of a legal fiction. Where the dosage is enough to bring about the death of a person, and death in fact resulted from administering the drug, it is difficult to suggest that the doctor's action did not cause the death. The fact that the underlying medical condition would have brought about the patient's death in due course does not alter the causative link between the administration of the medication and death. The third possible justification for the defence is that giving a patient a high dose of pain-relieving drugs is lawful because it constitutes caring for the living patient, and is therefore in the patient's best interests. However, some have argued that it cannot be regarded as care of a living patient to give that patient a lethal dose of a drug.[28]

Question 4 asked whether a mentally competent adult patient should be able to refuse medical treatment, including life-saving treatment. Again, the legal position is clear. A mentally competent adult is entitled to refuse medical treatment, even if such treatment is necessary to save that person's

[26] *R v Adams (Bodkin)* [1957] Crim Law Rev 365. Although this case has not been expressly adopted by Australian courts, it is widely regarded as representing the Australian legal position.
[27] Skene, n 17, pp 220-221.
[28] *Airedale National Health Service Trust v Bland* [1993] AC 789 at 865.

life. A doctor who administers treatment to a patient who has expressly refused it will have committed an assault and will be liable to prosecution accordingly.[29] A total of 28 politicians (85% of respondents to the survey) answered this question and 24 of them (86% of those who responded to this question) thought that a patient should be able to refuse treatment.

Again, it is interesting to compare the legal and ethical implications of the scenarios outlined in Questions 1 (assisting a patient to die) and 4 (refusing treatment), particularly when considering refusal of life-saving treatment. Although the legal consequences for health care professionals discussed above are very different, both scenarios present similar ethical considerations. In both cases, a doctor is able to bring about the death of a patient either by assisting her or him or by not providing the treatment needed for the patient to stay alive. Further, in both cases, the doctor is so acting in response to a request from a patient who, when faced with the alternative, wants to die. It might seem arbitrary to a patient seeking to end her or his life that whether the health care professional is legally able to be involved depends on the particular medical condition of the patient and whether there is treatment that he or she is able to refuse.

It is also instructive to compare responses across Questions 1, 3 and 4. Logically, if a respondent answered "yes" to the first question (allowing a doctor to assist in a patient's death), he or she would be expected to answer "yes" for the other two questions. While this was generally the case, one respondent agreed with permitting a doctor to assist in a patient's death (Question 1) and allowing a doctor to give increasingly large doses of a drug (Question 3), but did not agree that a patient should be able to refuse medical treatment. Another, while agreeing that a doctor should be able to assist in a patient's death (Question 1) and that a patient should be able to refuse medical treatment (Question 4), did not believe that a doctor should be able to give increasing doses of a drug to a patient if this could hasten death (Question 3).

The fact that some responses appeared to be internally inconsistent, or at least difficult to understand, may reflect the complexity of the ethical and moral considerations involved in such decisions. Those responses that disagreed with the established medical and legal views, for example that doctors should be required to provide medical treatment even if the patient refuses, may also suggest a lack of understanding of the existing legal regime. It would be interesting to see if any of these responses would have been different if the respondents were aware of the law as it currently stands.

THE IMPORTANCE OF OPEN POLITICAL DEBATE

The law in Australia on assisted death and euthanasia is the same as the law in other common law countries. Since the Commonwealth Government repealed the Northern Territory legislation facilitating assisted death,[30] doctors can be protected from prosecution for engaging in voluntary euthanasia or assisting patients to end their lives only in Oregon, The Netherlands and Belgium.[31] However, the fact that our laws are in step with those in most other jurisdictions does not justify a closed-door approach to this issue. Indeed, there are two reasons why an open political debate that includes the wider community needs to take place.

The first reason is that the community expects such debate to occur. This is evidenced in a number of ways. First, some of the politicians who responded to the survey recognised the need for public debate. One respondent observed:

> There is a great deal of community concern regarding euthanasia… I would like to see public debates being organised State wide which would allow community members to obtain information across the spectrum without the hysteria which is so often associated with this debate.

Many of the other comments from politicians recognised the complex nature of the issues that need to be confronted and discussed. These matters need to be resolved through debate so that, if legislative reform occurs, those reforms can be responsive to these concerns.

[29] *Criminal Code* (Qld), s 245. The doctor may also be liable to a civil action for assault.
[30] *Rights of the Terminally Ill Act 1995* (NT) repealed by the *Euthanasia Laws Act 1997* (Cth).
[31] *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001-2002* (The Netherlands) provides protection in relation to both physician-assisted suicide and voluntary euthanasia while the *Death with Dignity Act 1998* (Oregon) protects medical practitioners only in relation to physician-assisted suicide. The recently enacted Belgium legislation protects a doctor who performs voluntary euthanasia, but is silent in relation to physician-assisted suicide.

Second, not only do some of our politicians believe that this topic should be publicly discussed, the community itself both in Australia and elsewhere has a significant interest in matters involving assisted death and euthanasia. This can be seen from the extensive interest that is generated when this debate is personified, as in the much-publicised case in Queensland in 2002 of Mrs Nancy Crick who wished to end her life to escape the pain and suffering she considered to be unacceptable. This was also the case recently in the United Kingdom when Mrs Diane Pretty, a 42-year-old woman suffering from motor neurone disease, a progressive neuro-degenerative disease for which there is no treatment, wanted to end her life.[32]

Further, as mentioned earlier, polls indicate community support for assisted death and euthanasia, and such support has been increasing over the years.[33] These results underscore the need for the issue to be debated.

Finally, public interest is also evidenced by the extent of professional literature devoted to the topic. Considerable attention is given to the topic of assisted death and euthanasia in both medical and legal journals.[34] Further, over the past decade, many surveys have been carried out by members of the medical, legal and social work professions to gather information on a variety of aspects of the debate, including the extent to which euthanasia currently takes place, the effect such practices have on the medical practitioners involved and the views of different groups in our community (including medical practitioners) on euthanasia.[35]

In contemporary Australian society, it is not surprising that the community wants a political debate to occur. People's views on assisted death and euthanasia often seem to be polarised. End-of-life decisions have touched or will touch many of us. Because assisted death and euthanasia are such personal topics and may impact on the lives of so many, the community as a whole would benefit from the issues being explored, information being disseminated and discussions occurring. Ordinary individuals want an open political debate, and one in which they can be heard.

The second and equally compelling argument for a political debate is the current state of medical practice. It is indisputable that health care professionals currently assist patients to die and engage in voluntary euthanasia practices. Many surveys of health care professionals carried out in Australia and elsewhere, together with, in some cases, quite public admissions from medical practitioners, confirm this to be the case.[36] Such professionals claim to be acting in their patient's best interests and often with the consent, or at the request, of their patient. While such action constitutes a criminal offence, medical professionals know that prosecution is unlikely. Nevertheless, the risk of prosecution always exists,[37] and creates an unacceptable environment in which to practise medicine.

Naturally, not all professionals engage in such practice. However, given that there is widespread recognition that it occurs, it is an insufficient response for governments to ignore its existence and, when the issue arises in the media, to merely focus attention on the increased funding being

[32] This case went to the European Court of Human Rights, Mrs Pretty seeking to establish that, under the rights conferred by the *European Convention on Human Rights*, she was entitled to obtain assistance from her husband to commit suicide. Mrs Pretty's claim was unsuccessful: *Pretty v United Kingdom* [2002] ECHR 2346/02.

[33] Skene, n 17, p 240, refers to the Morgan Gallup Polls of 1962, 1978, 1986, 1987, 1989 and 1990 and comments that support for doctors actively assisting patients to die has increased over the years. See also surveys referred to in the *Report of the Senate Legal and Constitutional Legislation Committee on the Euthanasia Laws Bill 1996* (March 1997), Ch 7.

[34] For example, Bagaric M and Amarasekara K, "Euthanasia: Why It Doesn't Matter (Much) What the Doctor Thinks and Why There is No Suggestion that Doctors Should Have a Duty to Kill" (2002) 10 JLM 221; Thynne K, "Implications of Legalising Euthanasia in The Netherlands: Greater Regulatory Control?" (2002) 10 JLM 232. Further, over recent years many articles on euthanasia have appeared in the *Medical Journal of Australia.*

[35] See surveys referred to above, nn 23 and 24 and 33.

[36] See, eg, Douglas CD, Kerridge I, Rainbird KJ, McPhee JR, Hancock L and Spigelman AD, "The Intention to Hasten Death: A Survey of Attitudes and Practices of Surgeons in Australia", e Medical Journal of Australia 2001: http://www.mja.com.au; Kuhse H, Singer P, Baume P, Clark M and Rickard M, "End-of-Life Decisions in Australian Medical Practice", e Medical Journal of Australia 1997: http://www.mja.com.au. See also Magnusson RS, *Angels of Death: Exploring the Euthanasia Underground* (Melbourne University Press, 2002) which provides extensive evidence of doctors who have admitted to being involved in euthanasia practices. The book details the experiences of 49 health care workers both in Australia and the United States in relation to their involvement with assisted death and euthanasia.

[37] In *R v Cox* (unreported, Winchester CC, 18 Sept 1992) (see above n 19), the police were alerted to the situation because a relief nurse read the notes of the case and reported it to the hospital authorities. The authorities then advised the police.

channelled into palliative care. If the existing law is appropriate and reflects community expectations and standards, health care professionals who break the law should be prosecuted. If prosecutions do not occur because there is tacit approval of such practices, the law should be changed. Debate is required so that the community and government can fully understand existing practice and reasons for that practice, and formulate a view as to its appropriateness.

There is another important dimension regarding medical practice that suggests a sensible political debate must occur. As the law currently exists in all States and Territories other than South Australia and now Queensland, doctors and others are placed in an unenviable position because a degree of uncertainty exists about the protection afforded by the doctrine of double effect. This doctrine stems from an English decision[38] and, although widely regarded as forming part of Australian law, it does not sit comfortably with the various States' and Territories' criminal law. For example, the *Criminal Code* (WA) makes any action that hastens the death of a person a criminal offence.[39] Administering increasing doses of medication that results in the death of a patient may be regarded as such conduct. Doctors who act in a patient's best interest and in accordance with accepted medical practice should not have to wonder whether their actions are protected under the law.

UNDERSTANDING AND PROGRESSING THE DEBATE

If it is accepted that there are cogent reasons for politicians, and indeed the community, to think more about the issues of euthanasia and assisted death, the emphasis must then shift to the most effective way to progress that debate. One of the main stumbling blocks encountered has been concern about the extent to which euthanasia might be carried out by medical practitioners without consent of the patient, and perhaps at the urging of relatives of the patient. Safeguards to prevent this sort of abuse are an important part of progressing this political debate and so are addressed in some detail in this section.

Also considered are possible ways that the political debate could be progressed. Both a useful short-term measure as well as a forum for tackling the more significant goal of promoting genuine consideration of the issues of euthanasia and assisted death by both politicians and the community are suggested. Although some of these observations and recommendations are made in a Queensland-specific context, there is no reason why these comments would not be applicable in those jurisdictions in which the issue has not yet made it onto the political agenda. First, however, the importance of the views of individual Members of Parliament, some of which have been revealed through the survey, will be considered.

Role of Members of Parliament

Members of Parliament in all jurisdictions play a very important role in the euthanasia debate. As public figures, their contribution to this discussion is going to be influential, but more importantly, any change to the law requires a majority of them to agree. However, it is their role as *individuals* that is particularly interesting (and significant) because any proposed legislation dealing with the subject of euthanasia would probably be decided on a conscience vote, as was the case in the Northern Territory and in the Federal Parliament.[40]

But how is a conscience vote exercised? One of the obvious questions is whose conscience is it: that of the individual politician or the constituency that he or she represents? There is surprisingly little academic writing that addresses this particular issue.[41] It is, however, part of a wider debate about the

[38] *R v Adams (Bodkin)* [1957] Crim Law Rev 365, n 26.
[39] *Criminal Code* (WA), s 273.
[40] Indeed, Premier Gallop has promised to allow a conscience vote for Labor MPs on Western Australia's *Voluntary Euthanasia Bill 2002* (WA): see "Death Bill a Possibility", *The West Australian*, 4 March 2003.
[41] For two very different and interesting examples of writing in this area see Broughton S and Palmieri S, "Gendered Contributions to Parliamentary Debates" (1999) 34 *Australian Journal of Political Science* 29; Richards PG, *Parliament and Conscience* (Allen & Unwin, 1970).

role of parliamentarians in general and whether they should act as "agents" of their constituents or as "trustees" on their behalf.[42]

The "politician as agent" model involves merely carrying out the instructions of an electorate so the conscience vote would be based on the views of that group of people.[43] The "politician as trustee" role is a different one and requires a politician to exercise her or his best judgment (presumably having considered the views of the electorate) in which case the relevant conscience would be that of the individual politician.

It is likely that any conscience vote on this issue would be based on the "trustee" model. Although there has been only limited academic investigation, it seems that this is how the votes on the issue of euthanasia in the Northern Territory and in Federal Parliament were cast. Broughton and Palmieri studied voting on the *Euthanasia Laws Bill 1996* (Cth) from a feminist perspective and their approach, as well as some of their conclusions, suggests that politicians tended to see their vote as being determined by their own conscience.[44] This is consistent with Federal Parliament voting to overturn the Northern Territory legislation despite the strong community support for legalising euthanasia.[45] This is also consistent with views expressed by the Prime Minister and the Federal Treasurer that they would follow their own consciences when voting on stem cell research.[46]

There has been some discussion of the alternative role for politicians, that of being an agent of her or his electorate. For example, in debates leading up to the passage of the *Rights of the Terminally Ill Act 1995* (NT), a few members of the Northern Territory's Legislative Assembly discussed having canvassed their electorates' views and the importance of being guided by this.[47] However, in practice this does not seem to be the approach taken by politicians so it is likely that Members of Parliament considering an assisted death or euthanasia Bill would cast their vote based on the trustee model.

If this is so, then the views of politicians *as individuals* are of critical importance to any debate on euthanasia. The results of the survey discussed above could give an indication as to how such a vote might unfold in Queensland. However, undoubtedly there will be additional complications that are not reflected in an anonymous survey.[48] For example, one might be the existence of an informal party or faction line. Another complication is whether concerns about re-election may intrude into a decision on how to vote. The lack of political mileage in this sort of reform has already been discussed.

Despite this, the individual consciences of politicians remain an important consideration in the debate on euthanasia and assisted death, and indeed, this highlights the need for further discussion. Because any decision will be made by the consciences of a jurisdiction's Members of Parliament, a full political debate in which the community can participate is needed to inform and shape their views.

An interim measure – Enact the doctrine of double effect

For the reasons suggested in this article, it may be some time before euthanasia legislation is enacted in any Australian jurisdiction. While Bills are currently before the South Australian, Western Australian and New South Wales Parliaments, their enactment is unlikely without government support or at least acquiescence. Until euthanasia legislation is enacted, one problem outlined in this

[42] For a recent and brief discussion of this debate, see Bishop P, "Reconnecting Representatives: Participating in a Representative Democracy", unpublished conference paper, Constitutional and Parliamentary Reform for South Australia (17-18 August 2002, Adelaide). Bishop explores these two models in the context of two recent political consultation exercises.

[43] Although one of the obvious difficulties with this model is actually discovering what the views of your electorate are.

[44] Broughton and Palmieri, n 41 at 31, 33, 43. This matches with Richards' study of conscience votes on a number of issues in England during the 1960s. His view is that the "tradition of British representative government" meant that politicians were sensitive to constituents' views but not bound by them: see Richards PG, *Parliament and Conscience* (Allen & Unwin, 1970), pp 203-204.

[45] Broughton and Palmieri, n 41 at 33.

[46] J Howard, transcript of interview, Canberra, 21 June 2002, pp 1-2 (available at http://www.pm.gov.au/news/interviews/2002/interview1710.htm); P Costello, transcript of interview, Canberra, 4 April 2002, p 3 (available at http://www.treasurer.gov.au/tsr/content/transcripts/2002/015.asp).

[47] For example, Mrs Padgham-Purich, Northern Territory, Legislative Assembly, *Parliamentary Record*, No 11, 24 May 1995, pp 3635-3641. But cf Mr Bailey, Northern Territory, Legislative Assembly, *Parliamentary Record*, No 11, 24 May 1995, p 3642.

[48] Some of these considerations are explored further in the context of particular English case studies in Richards, n 41, Ch 10.

article that remains is that the existing law relating to the administration of palliative care is unsatisfactory in all Australian jurisdictions except South Australia and now Queensland. Health care professionals are required to work in circumstances where they risk prosecution even when acting in the best interests of their patient and in accordance with accepted medical practice. Passing legislation like the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) or the *Criminal Code (Palliative Care) Amendment Act 2003* (Qld) would provide at least some degree of protection for our health care professionals who practise in difficult and emotionally charged circumstances. It would also have the added advantage of operating as a springboard for further debate.

Ensuring sufficient legislative safeguards

One of the main obstacles to a productive and open political debate on euthanasia has been concern about the sorts of safeguards needed to ensure the practice of euthanasia does not become commonplace and also to protect against abuse. If assisted death and euthanasia were permitted by law, there would need to be defined limits within which such practices could occur. Even individuals who support law reform struggle with establishing acceptable parameters of conduct. Most in favour of reform seem to believe, for example, that voluntary euthanasia should be available to a mentally competent adult patient who is terminally ill and suffering unbearable pain for which no adequate remedy is available. However, there may be less support for euthanasia where the patient, for example, is in the early stages of a terminal illness. The patient may be able to manage the pain through medication, but does not wish to experience the degeneration or suffering associated with a drawn-out death or is unwilling to take the large doses of medication that may be required to relieve the pain.[49] At the other end of the spectrum, most would be concerned about the possibility of a young adult suffering some form of mild and treatable depression being able to obtain assistance in bringing about her or his death.

A number of the politicians who indicated support for reform emphasised the need for adequate safeguards to be part of any legislation enacted. Question 5 of the survey asked the politicians whether there were any other comments they wished to make in relation to the issues raised in the survey. Some of the politicians who supported reform made the following comments:

> Only that the decision, as I have said, should be made over a period of time – not a sudden "I want to die" response which may be regretted with different treatment.
>
> The views expressed here are my own, and are general in nature. I would need to be satisfied with the particular provisions of any Bill before supporting it.
>
> Decision should be made by specially qualified Board within defined time frames. Certain parameters and strict professional guidelines.
>
> It's a tough one to legislate for. But I do not want others making a decision to kill me. I want the right to starve or whatever to death and this will probably require prior advice to medico.

Politicians who responded that, *in some circumstances*, a doctor should be permitted to assist a patient to bring about her or his death were then asked some specific questions about those circumstances.

Terminal illness

Question 2(a) asked whether assistance should only be provided if the patient is suffering from a terminal illness. Of the 18 who answered "yes" to Question 1, 17 (94%) responded to this question. Of those people, 11 (65%) responded that a patient should be terminally ill before being able to access such assistance.

Severe pain or distress for which no remedy is available

Question 2(b) asked whether assistance should only be provided if the patient is in severe pain or distress for which no remedy is available. Again, there were 17 respondents and again, 11 of those

[49] There are, of course, other circumstances in which people have indicated a desire to end their lives. For example, Mrs Diane Pretty (see further n 32) wished to end her life because of what she described as the indignity she had to endure of being totally reliant on others for all aspects of her care. Mrs Pretty also indicated that she was scared to die in the manner that usually occurs for someone with her disease, namely an inability to swallow or breath. Similar fears were held by a Victorian woman, Ms Sandy Williamson, who also suffered from a motor neurone disease. It was reported that Ms Williamson died after overdosing on barbiturates in July 2002: "Death Comes At Last", *Herald Sun*, Melbourne, 30 July 2002.

people (65%) responded that a patient should be suffering in this way before obtaining assistance. It is interesting to observe that there was not complete correlation between the 11 who answered "yes" for Question 2(a) and "yes" for Question 2(b). Only 7 (41%) answered "yes" for both. Perhaps these results reflect the fact that even for those who agree, in principle, that medical practitioners should be able to assist patients in some circumstances, there is considerable divergence in view as to when such assistance should be available.

Patient is an adult

Question 2(c) asked whether assistance should only be provided if the patient is over the age of 18. Of the 17 who answered this question, 9 of those people (53%) agreed that the patient should be an adult.[50]

Other restrictions

The politicians were asked whether, apart from the above matters, there should be any conditions or restrictions before assistance could be given. Examples mentioned in the survey were that the patient be required to consult a psychiatrist or health care professional other than the patient's medical practitioner, or that there be a cooling-off period. All 17 of the politicians who answered Question 2 indicated that restrictions were needed and most made suggestions as to what they should be:

- discussion with family/consideration of alternative options (four respondents);
- consultation with psychiatrist/counselling (eight respondents);
- alternative medical opinion, for example, from two or more medical practitioners not associated with the patient's family (six respondents);
- cooling-off period (five respondents);
- informed consent (two respondents);
- review by a board/panel/team of medical multidisciplinary staff (two respondents).

It is interesting to compare the views of these Queensland politicians on safeguards with those that appear in legislation. The safeguards set out in the repealed Northern Territory legislation were comprehensive.[51] A medical practitioner was permitted to assist a patient to end her or his life only if all of the conditions prescribed by the legislation had been met.[52] These requirements included the following:

- the patient has a terminal illness;
- the patient is experiencing pain, suffering and/or distress to an extent unacceptable to the patient;
- the patient is 18 years or over;
- any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the object of allowing the patient to die a comfortable death;
- a second medical practitioner and a qualified psychiatrist have examined the patient;
- the second medical practitioner has confirmed:
  - – the first medical practitioner's opinion as to the existence and seriousness of the illness;
  - – that the patient is likely to die as a result of the illness; and
  - – the first medical practitioner's prognosis.
- the qualified psychiatrist has confirmed that the patient is not suffering from a treatable clinical depression in relation to the illness;
- the medical practitioner has informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available;

[50] One of these said that it might be appropriate in the case of a patient who was 15 or 16 years of age (presumably the implication was that it should be only available if the patient was sufficiently mature to understand the nature of the decision).
[51] These safeguards were also adopted in the *Rights of the Terminally Ill Bill 2001* (NSW) which was defeated in March 2002.
[52] *Rights of the Terminally Ill Act 1997* (NT), now repealed, s 7.

- the medical practitioner is satisfied that the patient has considered the possible implications of the patient's decision for her or his family;
- the medical practitioner is satisfied, on reasonable grounds, that the patient is of sound mind and that the patient's decision to end her or his life has been made freely, voluntarily and after due consideration;
- not less than 48 hours has elapsed since the signing of the certificate of request and the provision of the assistance.

In addition to the above safeguards, various formalities were prescribed in the legislation including such things as signing and witnessing of requests for the provision of assistance and the procedure to be followed if the patient was physically unable to sign the certificate.

The prerequisites that must be satisfied under the proposed South Australian and Western Australian legislation are less onerous. Under the *Voluntary Euthanasia Bill 2002* (WA), a request for euthanasia may be made by a person who has "a medically-diagnosed illness or condition that, as it progresses, will most likely cause the death of that person" and "by reason of the pain and suffering or debilitation associated with the actual progress of that illness or condition, has no desire to continue living". The person must be examined by two medical practitioners, neither of whom must be a psychiatrist, to be satisfied that these conditions are met.[53] As with the repealed Northern Territory legislation, the medical practitioner is required to inform the person of treatment options, including palliative care, and there is a 48-hour cooling-off period after making the request before assistance is provided by the medical practitioner.

Under the *Dignity in Dying Bills 2002 and 2003* (SA), a person may make a request for voluntary euthanasia if he or she is "hopelessly ill".[54] This term is defined in the Bills to refer to an injury or illness that results in serious mental impairment or permanent deprivation of consciousness or one that seriously and irreversibly impairs the person's quality of life so that it has become intolerable to that person. There is not a requirement that the person be suffering from a terminal condition, nor that the person be experiencing pain, suffering or distress to an extent unacceptable to the person.[55] Again, before the request is made, the medical practitioner must provide the patient with specified information including diagnosis, prognosis and treatment options.[56] After making the request, the person must be examined by a second medical practitioner who must also be satisfied (amongst other things) that the person is hopelessly ill. These Bills also provide for a 48-hour cooling-off period.

Safeguards also exist in the legislation in Oregon, The Netherlands and Belgium, although again they are not as exhaustive as those that existed in the Northern Territory. In The Netherlands, for example, legislation facilitates euthanasia if the doctor holds the view that the patient's suffering is lasting and unbearable. Moreover, euthanasia is available to children as young as 12.[57] In Oregon, a person may make a written request to obtain medication for the purpose of ending her or his life if suffering from a terminal illness. There is no requirement regarding pain and suffering. A two-tier test operates in Belgium. The patient must be in a hopeless medical situation, and be constantly suffering physically or psychologically. As in Oregon, the patient's request must be in writing. Where the patient is in the terminal phase of her or his illness, only one doctor need be involved. If the patient wishes to die at an earlier time, however, the doctor must consult with a second medical practitioner.

It is unrealistic to imagine that agreement will be reached on the circumstances when it will be acceptable to assist a patient to die. Individuals will have different views on this. Some may not think

[53] In addition, the medical practitioners must be satisfied that the only medical treatment available is palliative, the request is not wholly or substantially referable to a state of clinical depression that is treatable, and that the applicant has made the request freely with full knowledge of the consequences.

[54] The request may be a "current request" that is effective as soon as it is made, or an "advance request" which operates when the person becomes hopelessly ill.

[55] The medical practitioner must be satisfied, however, that the patient is not suffering from treatable clinical depression or, if the patient is, that treatment is unlikely to influence the patient's decision to request voluntary euthanasia.

[56] A request must be witnessed by a medical practitioner and two adults who must be satisfied that the person is of sound mind, understands the nature of the request and does not appear to be acting under duress.

[57] For children aged between 12 and 16, however, a parent or guardian must agree with the termination of life or assisted suicide. For children aged 16 to 18, a parent or guardian must have been involved in the decision-making process, but there is no requirement for them to agree or approve.

that a terminal condition should be the trigger. For them, unacceptable levels of pain for which remedy is unavailable should be enough. Others may not wish to remain on powerful medication on a long-term basis to manage their pain. However, the fact that there will be disagreement and that the debate is a difficult and often distressing one is not a satisfactory reason for not confronting it.

The Northern Territory legislation, while progressive in that assisted death was facilitated for the first time in a common law country, was conservative in terms of the prescribed safeguards. The legislation currently being considered in Western Australia and South Australia imposes fewer requirements on people seeking assistance to end their lives. If the community were aware of the range of safeguards that could be legislatively enshrined, some of the concerns aired publicly by politicians and others, and no doubt felt privately by many members of the community, could be alleviated.

In an interview about Mrs Nancy Crick's desire to end her life, the Queensland Premier, Mr Peter Beattie commented that he "understood the desire of Mrs Crick to be with loved ones on her death bed but it was impossible to frame euthanasia legislation that would protect against greedy relatives".[58]

Any appropriately drafted legislation would address the Premier's concerns about euthanasia being done without the consent of the patient. The Northern Territory legislation did not provide for involuntary euthanasia, as there was no provision for anyone other than the patient to seek assistance to die.[59] The extensive nature of the safeguards ensured that such action could be taken by the patient only if the patient wished that to occur and her or his medical practitioner was satisfied that it was the patient's free choice. Although designing appropriate safeguards is one of the challenges in this area, these concerns should not be allowed to stifle an open political debate.

Overcoming political barriers

A full public discussion about safeguards that could be included in legislation may address concerns that exist in some sectors of our community. However, perhaps the greater challenge is overcoming the political barriers that seem to exist in some jurisdictions, and which operate to stifle the debate. For example, despite broad community support for law reform in Queensland and the fact that it is supported by the majority of politicians who responded to this survey, reform does not appear to be on the political agenda of the Queensland Government. According to a document released by the Premier's Department:

> The Queensland Government does not support euthanasia and does not intend to change the legislation with regard to euthanasia at this time.[60]

Before the Commonwealth enacted the *Euthanasia Laws Bill 1996* (Cth) which overturned the Northern Territory euthanasia law, the Bill was referred to the Senate Legal and Constitutional Legislation Committee. This Committee investigated the issues surrounding euthanasia and reported on the proposed Commonwealth Bill. As part of its review, the Committee held three public hearings (in Darwin and Canberra) and sought (through advertisements in the press) submissions from members of the public. The Committee also invited key individuals and groups to lodge submissions. Despite the brief consultation period of approximately one month, 12,577 responses were received. The report of the Committee,[61] published in March 1997, provided an informed platform for debate on the Commonwealth Bill.

As described in this article, the euthanasia debate has progressed on a number of levels since March 1997. Perhaps it is time for further investigation to take place. It is suggested that in Queensland a taskforce should be established independent of the government with a mandate to investigate the issue of euthanasia, to generate an informed public debate and to compile a report of its findings. It could function in a way similar to the Senate Committee that reported on the *Euthanasia Laws Bill 1996*

[58] "Suicide Queue Keeps Euthanasia Debate Alive", *Sydney Morning Herald*, 25 May 2002.
[59] This is also the case in The Netherlands, Oregon and Belgium, and under the legislation proposed in Western Australia and South Australia.
[60] This document was released to the authors in the course of carrying out the survey.
[61] Report of the Senate Legal and Constitutional Legislation Committee. This report is available at http://www.aph.gov.au/senate/committee/legcon_ctte/euthanasia/euthan6.pdf.

(Cth). This could be a convenient and politically safe model in those jurisdictions, such as Queensland, where there appears to be some political resistance to considering these issues. It would enable a government to provide a public forum for euthanasia to be discussed but, if unconvinced by the findings of this independent body, it would still have the freedom to reject those findings.

If such a taskforce were established in Queensland, it would have two "clients". The first is obviously the government as its support, or at least acquiescence, is needed before reform can be seriously considered. The second client group, and there is some overlap, is the 89 Members of Parliament. If legislation dealing with the issue of euthanasia is introduced, the individual consciences of the Queensland politicians will play a decisive role. It is suggested that each of those 89 decisions, although based on each person's own views, would benefit from a comprehensive and independent review of the issues.

The taskforce's investigations would include reviewing existing medical practices through consultation with health care professionals including doctors, nurses and specialists. Consultation with stakeholders such as Right to Life, Voluntary Euthanasia Societies and church groups should also occur. To facilitate the public debate, the taskforce should disseminate information about how medicine is currently being practised and any difficulties that existing laws pose for health care professionals. They should also hold public forums during which informed debate could take place. Research into how legislation is operating in other jurisdictions should also be undertaken.

The taskforce should be constituted by individuals who have expertise in this area but who are independent of interest groups and stakeholders. Members could include representatives of the government, a range of health care professionals including, perhaps, doctors, nurses, social workers and specialists working in palliative care, researchers in the area and possibly a legally qualified person. After extensive liaison and consultation with interested individuals and groups, the taskforce should report its recommendations to the government and indeed all of Queensland's politicians.

CONCLUSIONS

Euthanasia is an issue that simply will not go away. Proposals for legislative reform both in Australia and overseas as well as the frequent media attention reflect the public's interest in assisted death and euthanasia. An issue that attracts this much attention cannot be avoided. Although this topic involves confronting issues, it is not an appropriate response for governments to ignore public opinion and avoid placing the issue on the political agenda.

The difficulty in trying to find an acceptable political solution is acknowledged. Many people have strong views, and there is little common ground between some interests. A consensus is unlikely. However, a decision of some kind should be made and that decision should be the product of extensive public investigation and open political debate.

In introducing his first Private Member's Bill into Queensland Parliament, Mr Wellington said:

> I have searched the world for an answer and have spoken to hundreds of people involved with the care of the terminally ill, including doctors, nurses, ministers of religion and palliative care workers.[62]

State and Territory governments have an obligation to do the same by consultation with their doctors, patients and people.

POSTSCRIPT

Since this article was submitted for publication, the Queensland Bill, the Criminal Code (Palliative Care) Amendment Bill 2003, received Royal Assent and commenced operation.

[62] Queensland Parliament, *Hansard*, 19 June 2002.